NHS AT 60

A centrally funded health service, free at the point of delivery

Funding the NHS solely through taxation has led to tensions throughout its history. But, as **Tony Delamothe** reports in his fourth article on the NHS, it still looks like the most efficient option

The vision for a national health service came with the haziest of price tags, and it wasn't long before the bills started piling up. To balance the books, patient charges were introduced in 1951 for dentistry and ophthalmic services, and for prescriptions a year later. To curb the perceived profligacy of the service's early days a ceiling was set on NHS spending—the annual contribution from direct taxation was limited to about £400m (€500m; $780m) at 1950 prices.[1]

Patient charges still exist (mainly for dental services and prescriptions), but they currently comprise just 1.3% of total NHS spending in the United Kingdom—the lowest proportion since charges were introduced. The remaining 98.7% of NHS spending is centrally funded, with 80.3% coming from taxation and 8.4% from National Insurance.[3]

So, even with medical advances, enhanced expectations, and increased life expectancy, the modern NHS is within 1.3% of delivering on the original vision, but this achievement attracts minimal interest. The topic of fervent debate since the early 1950s has been how much money should be spent on the NHS and whether its original funding model is the right one to provide it.

How big a slice of the cake?

How much money to spend of course depends on what you want to buy and how much it costs. Since the aspiration is a "comprehensive health service" it's crucial to define exactly what that means. This returns us to the topic of last week's article: whether the NHS should provide for people's healthcare needs (as defined by experts) or their demands (as defined by them) (fig 1).[4] The vagueness of what the NHS was expected to deliver was first pointed out by the Guillebaud committee in 1956. Set up by the government to cost an adequate service, it concluded: "There is no objective and attainable standard of "adequacy" in the health field . . . There is no stability in the concept [of an adequate service] itself."[5]

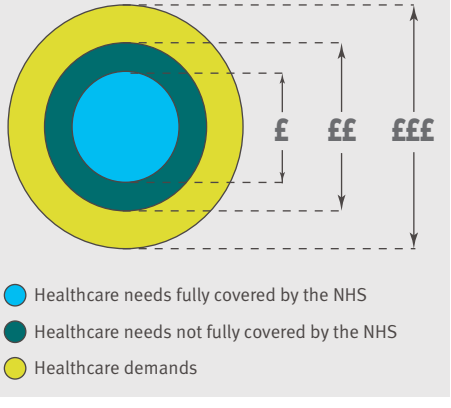


Fig 1 | Costs of a comprehensive health service

NHS pledges on charges[2]

"There are to be no fees or charges to the patient, with the following exceptions:

(i) There will be some charges. . . for the renewal or repair of spectacles, dentures and other appliances, where this is made necessary through negligence. . .

(ii) There will be charges (taking into account ability to pay) for the provision of domestic help under the Bill for certain good or articles (eg supplementary foods, blankets etc) which may be provided in connection with maternity and child welfare or the special care or aftercare of the sick.

(iii) It will be open to people if they wish, in certain cases, to pay for additional amenities within the arrangements of the service—eg to pay for articles or appliances of higher cost than those normally made available, or to pay charges for private rooms in hospitals"

The Guillebaud committee also settled early doubts that NHS spending was out of control. It found that it was delivering a high quality service, economically, and could uncover no evidence of widespread extravagance.[1] Concerns that financial profligacy has expanded the NHS's share of the cake have dogged the service since its birth, despite the fact that it controlled spending more effectively during its first 50 years than any other healthcare system in the world.[6]

In 2001, the Treasury asked Derek Wanless, former chief executive of the National Westminster Bank, to quantify "the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay."[7] He noted how far the UK had fallen behind other countries in health outcomes. "We have achieved less because we have spent very much less and not spent it well."

Just how much less is apparent from figures 2 and 3. Wanless calculated that between 1972 and 1998 Britain spent £220bn less on health care than the European Union average. Figure 2 suggests that the total shortfall between 1963 (when UK spending fell below the EU average) and 2006 (when the UK spending once again matched the EU average) would be even greater. Wanless endorsed "the need for a very substantial increase in resources for health and social care"[7] that had already been announced by the prime minister, Tony Blair.

Which funding model?

More of the same (taxation)

During "the most expensive breakfast in British history"—Mr Blair's TV interview with David Frost on the BBC's *Breakfast with Frost* in January 2000—the prime minister had pledged to increase spending on the NHS from 6.8% of gross domestic product in 1997 to 9.2% in 2008, matching European levels of spending. These billions would be raised through taxation. Such a tax based system doesn't have to be underfunded, wrote Simon Stevens, who later became Mr Blair's health policy adviser. "It is a fiscal choice."[9] At a stroke the time honoured argument against increased spending on health—taxpayer resistance—lost its power. In fact, there's never been good evidence for such resistance within the UK, and experience elsewhere suggests that healthcare spending increases as countries get richer (fig 4).

Is there a limit to what proportion of a country's gross domestic product it's prepared to spend on health? In 2005, the UK spent 8.3% of its gross domestic product compared with

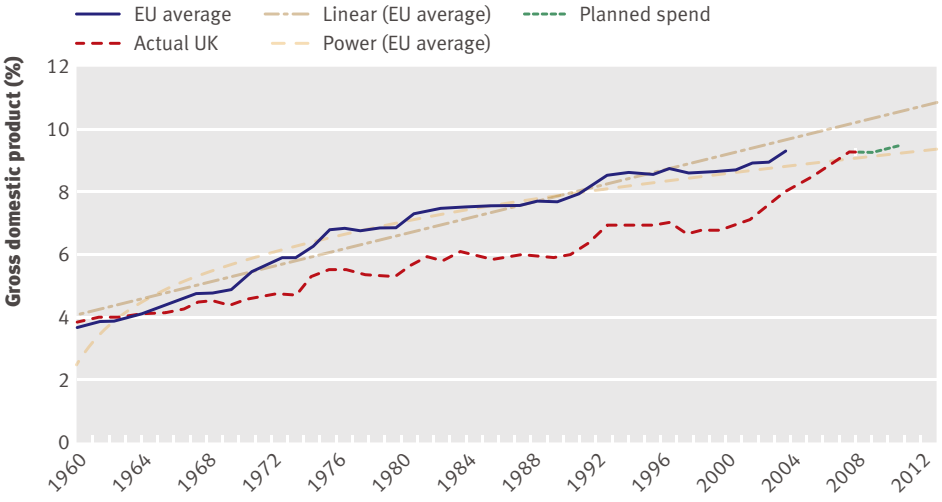


Fig 2 | UK and EU total spending on health care. (EU data were unavailable after 2004 but are projected using linear and power models)

the United States's 15.3%, France's 11.1%, and Germany's 10.3%.[8] So it would be premature to argue that healthcare spending in the UK had peaked.

More of the same (patient charges)

The dwindling proportion of NHS costs provided by patient charges—down from 5.3% in 1962 to an all time low of 1.3% in 2006—tells its own story.[3] This total is likely to go even lower as Wales began phasing out prescription charges in 2003 and Scotland has just approved their phasing out.

As Rudolf Klein reminds us, if charges are to be more than nominal, then ways to exempt the least well off need to be found.[6] And exemptions reduce how much the charges yield: half of England's population is exempt from prescription charges; 88% of prescriptions dispensed in England were free to patients.[3] Aneurin Bevan, the NHS's architect, argued against charges as they entail administrative complexity and costs, not to mention a return of the dreaded means test for health care.

Those wanting to extend user charges have a hard case to argue. Wanless quoted evidence that charges can discourage people from seeking treatment or can direct them to other parts of the healthcare system that don't levy charges. Activity may be diverted to more costly parts of the system or delayed until treatment is more expensive.[5] A recent *BMJ* paper on the doubling of hospital admissions for drainage of dental abscess provides an example of this.[10]

When user charges are meant to discourage wasteful use of resources, the behaviour of the less well off is likely to be affected more than that of those who can easily afford the payments.[5] In Sweden, greater equality of use of health services during the 1970s and 1980s followed a reduction in user fees, while widening inequality in the 1990s followed large increases in user charges.[11]

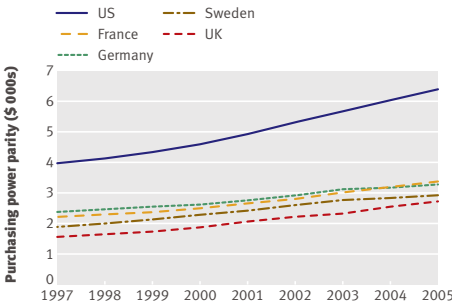


Fig 3 | Total expenditure on health per capita in selected countries[8]

Social insurance

In social insurance systems contributions related to earnings are paid by either employers or employees (or both) to social insurance funds. These funds have little incentive to contain the payments they make to healthcare providers,[5] although the Netherlands has recently introduced competition among insurers.[12] Administrative costs tend to be higher when multiple sickness funds fragment healthcare purchasing.

Social insurance in its commonest manifestation loads substantial costs on to employers, making it more expensive to create jobs. Economists believe that it's partly the absence of such costs that has contributed to the flexibility of the UK's labour market, providing a competitive advantage over some other western European economies.

Private insurance

In 2005, the United States spent 15.3% of its gross domestic product on health care, or $6401 per person, compared with the UK's 8.3% or $2724 per person.[8] Economists Paul Krugman and Robin Wells believe the culprit for the discrepancy is "the unique degree to which the US system relies on private insurance." The extra spending doesn't buy better health outcomes; in many cases the US's are worse than Britain's.[13]

Private medical insurance seems the most problematic of the alternatives on offer. Wanless reports that systems which rely on private insurance show poor cost control, demand led spending, absent global budgets, and fragmented commissioning of services.[5] Krugman and Wells attribute the higher costs of systems based on private medical insurance to administration, including the large sums private insurers spend trying to identify and screen out high cost customers. In addition, prices for goods and services are likely to be higher because insurers lack bargaining power with suppliers, especially drug companies.[13]

When private insurance is the sole means of cover, access to health services is determined by the level of insurance cover that an individual can afford to purchase. Usually the poorer, older, and less healthy in society will be considered by private insurers to have the greatest health risks and therefore face the highest premiums.[5] In the US this has led to about 15% of the population having no access to health services other than the last resort of the emergency room—either because they cannot afford the insurance premiums or because private insurers have deemed them too risky to insure. US insurers turn away 12% of all applicants, and more than 30% of people over 60. If the UK ditched the tax model of funding in favour of private insurance, says journalist Johann Hari, "we would have to recreate it inch by inch as private firms refused to insure more and more people."[14]

Copayments (top-up fees)

Should NHS patients be able to pay the cost of treatments not available on the NHS, while remaining NHS patients for the rest of their treatment? Examples include expensive drugs not approved by NICE or not provided by a primary care trust.[15] England's Department of Health currently denies patients this option, arguing that those who pay for part of their treatment thereby choose to become private patients for all of it. Anything else would contradict one of the fundamental principles of the NHS: "that treatment should be available on need and not on the ability to pay."[16]

But opponents counter that "the greatest iniquity and inequity is surely to disallow citizens and taxpayers their NHS entitlement in the name of fairness."[17] Last week, the BMA's annual consultants conference voted overwhelmingly for NHS patients to be allowed to "top up."[18]

Will the government be able to hold the line, with several legal challenges pending?[19] Could paragraph (iii) in the box at the beginning of this article be interpreted to mean that top-up fees are legitimate? If this chink opens up, private health insurers won't be far behind, offering cover for those health services that the NHS refuses. With this will come the inequities of private coverage documented immediately above.

Tax rules

Wanless couldn't find any alternative funding model to the UK's that would deliver a given quality of health care at a lower cost to the economy. Other systems seemed likely to prove more costly than the UK's, which came out as relatively efficient and equitable. "It delivers strong cost control and prioritisation and minimises economic distortions and disincentives, " he wrote. A key advantage was its fairness, "providing maximum separation between an individual's financial contributions and their use of health care."[5]

Previous considerations of alternative funding models have come to the same conclusions. In 1960, a government working party on NHS finance chaired by Frank Figgures was sceptical about alternatives to general taxation. Its arguments "proved apposite and convincing on the many future

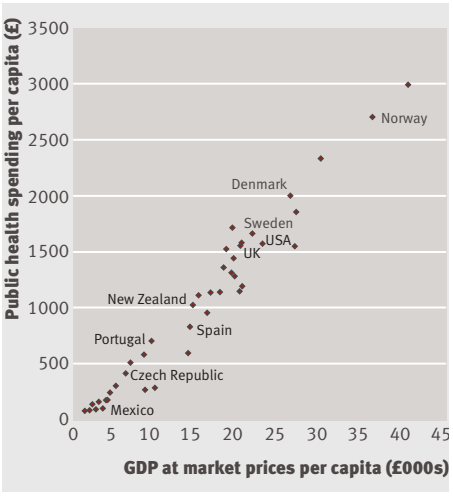
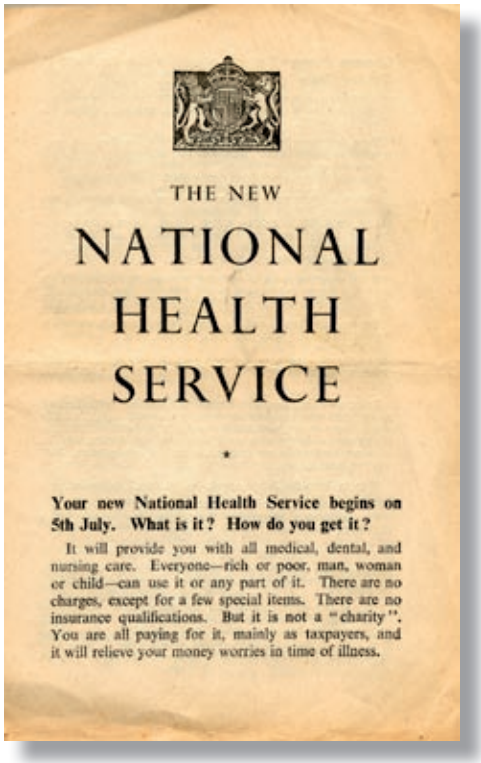


Fig 4 | Relation between public health spending per capita and gross domestic product per capita, OECD and EU countries[3]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occasions when alternative methods of funding the NHS were considered," writes NHS historian Charles Webster.[1]

One of these future occasions was the Royal Commission on the NHS in 1979. It declared itself unconvinced that the claimed advantages of insurance or charges outweighed "their undoubted disadvantages in terms of equity and administrative costs."[20] In 2000, *The NHS Plan* contained a section on why tax funding was best.[21]

Yet the hunt for a better funding model is never called off, with each new foray unfolding along similar lines. It begins with the NHS being judged as seriously underperforming. The real reason for this, whether admitted by the government of the day or not, is because not enough money is being spent on it. Early in the hunt comes sightings of the "bottomless pit" of insatiable healthcare demands, quickly followed by assertions that substantial increases in healthcare spending are "unsustainable." When asked for their advice, economists tell politicians that a tax based system provides governments and patients with the best deal. As a sideshow to the main event are the hucksters, peddling their own funding models, hoping that some of the billions spent on the NHS might end up in their pockets, or those of their backers.

But this doesn't look like happening any time soon. The NHS remains a centrally funded system, free at the point of delivery, with the exception of minimal patient charges. The package of services that the NHS has elected to provide looks unlikely to seriously stress the current tax based funding model. Arguably, taxation could be used to raise even more money for the NHS.

But whether the package of services the NHS has elected to provide is enough is the big question. Governments have been deliberately vague about what that package includes, which has served them well in the past. But the failure to be explicit about this means that sensible discussion on the funding of services that are outside this package is postponed indefinitely. Consumer action is making this position unsustainable for much longer.

Tony Delamothe deputy editor, *BMJ*, London WC1H 9JR
tdelamothe@bmj.com

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